CONFIDENTIAL **DHHS Restrictive Intervention Details Report** *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ Consumer's Social Security No _____ - _____ - _____

This form is used to report use of restrictive interventions for persons receiving publicly funded mental health, developmental disabilities and/or substance abuse (mh/dd/sa) services. Facilities licensed under G.S. 122C and unlicensed providers of community-based mh/dd/sa services must submit this form or a form with comparable information to the Local Management Entity (LME) responsible for the geographic area in which the service is provided. Failure to submit this report, as required by NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, may result in administrative actions being taken against the provider's license and/or authorization to receive public funding. This form may also be used for internal documentation of interventions, if required by provider policies or LME contract.

***Instructions*: Complete and submit this form to the local and/or state agencies responsible for oversight within 72 hours to report any restrictive intervention that (1) is administered inappropriately, (2) results in death, injury, discomfort or complaint or (3) is used in an emergency (not included in service plan). ♦ If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible. ♦ *NOTE*: *All* use of restrictive intervention, including planned use that is administered appropriately without discomfort or complaint and unplanned emergency use, must be documented in the consumer record, as required by NC Administrative Code 10A NCAC 27E .0104.**

***Page 1-3 Instructions*: The direct care staff person who is most knowledgeable about the intervention should complete pages 1-3 of this form as soon as possible and submit to the unit supervisor for review.**

INTERVENTION DETAILS

Date of intervention: ___/____/___ **Time**: ___: ___ ☐a.m. ☐p.m. **Consumer's Home LME:** _____

Facility: _____ **Host LME** *(LME responsible for geographic area where service is provided)*: _____

Intervention Type *(Check all that apply)*
- ☐ Isolation
- ☐ Seclusion
- ☐ Restraint – Standing
- ☐ Restraint – Sitting
- ☐ Restraint – Face Down

Intervention Duration: ____hrs _____mins

Intervention Specifics: *(Check only one)*
- ☐ NCI
- ☐ CPI
- ☐ Other_____

If over 15 minutes, who authorized the additional time?

Name _____

Title _____

Number of restrictive interventions in last 30 days: _____

Purpose of the intervention *(check all that apply)*:
- ☐ Prevent harm to self
- ☐ Prevent harm to others
- ☐ Prevent serious property damage
- ☐ Planned intervention (Person-Centered Plan date: _____/_____/_____

If planned, was intervention reviewed & approved by a Client Rights or Restrictive Intervention Committee prior to the intervention?

☐ Yes ☐ No Agency: _____ Committee: _____ Date: _____/_____/____

DESCRIPTION

Briefly describe what happened to cause a restrictive intervention, including specifics of the individual's behavior (e.g. frequency, intensity, duration), and actions leading to the behavior. Be specific. ***(Attach sheets if needed)***

Positive and/or less restrictive interventions attempted *(check all that apply)*:
- ☐ Verbal Redirection
- ☐ Distractions (e.g. take a walk)
- ☐ Impromptu treatment session
- ☐ Removing consumer from situation (verbal and physical prompts)
- ☐ Separation from group (verbal and physical prompts)
- ☐ Other _____

Description of results:

Rationale for using restrictive of intervention *(Be specific)***:**

HEALTH STATUS

Significant medical conditions identified previously:
- ☐ None
- ☐ Heart Condition
- ☐ Physical disabilities
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Other *(specify):* _____

Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 & 164.

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HEALTH STATUS INFORMATION

ITEM	INITIAL CHECK *(Prior to Intervention)*	ENDING CHECK *(Immediately after Intervention)*	FOLLOW-UP CHECK *(30 minutes after Intervention)*
Consciousness *Please explain any abnormality*:	☐ Alert ☐ Dazed ☐ Unconscious	☐ Alert ☐ Dazed ☐ Unconscious	☐ Alert ☐ Dazed ☐ Unconscious
Speech *Please explain any abnormality*:	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Breathing *Please explain any abnormality*:	☐ Normal ☐ Hard / Irregular	☐ Normal ☐ Hard / Irregular	☐ Normal ☐ Hard / Irregular
Movement *Please explain any abnormality*:	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Skin Color *Please explain any abnormality*:	☐ Normal ☐ Pale ☐ Flushed	☐ Normal ☐ Pale ☐ Flushed	☐ Normal ☐ Pale ☐ Flushed
Orientation *Please explain any abnormality*:	☐ Person ☐ Place ☐ Time	☐ Person ☐ Place ☐ Time	☐ Person ☐ Place ☐ Time
Affect / Mood *Please explain any abnormality*:	☐ Appropriate ☐ Inappropriate	☐ Appropriate ☐ Inappropriate	☐ Appropriate ☐ Inappropriate

Describe the person's behavior after the intervention:

Was the person monitored continuously during the intervention and for 30 minutes afterward? ☐ Yes ☐ No

If not monitored continuously, provide an explanation:

Monitoring provided by: _____ _____
Signature / Title / Date *Signature / Title / Date*

Signature/Title of Staff Documenting Intervention _____ Date ____/____/____

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***Page 4 Instructions**: The supervisor of the service should review pages 1-3 of this form, complete page 4 and submit to the LME responsible for the geographic area in which the service is provided. If a consumer dies or is permanently impaired as a result of the intervention, this report must also be submitted to the consumer's home LME and to DHHS (see addresses below). Consumer deaths within 7 days of a restrictive intervention must be reported immediately. Providers have 72 hours to complete all other reports of restrictive intervention.*

STAFF

Name(s) of Staff Conducting Intervention	Current Certification				
	CPR	First Aid	NCI	CPI	Other
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____
_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	_____

EVALUATION

Describe the debriefing with the individual and/or guardian:

Describe the debriefing with staff: *(What could have been done differently to avoid the need for restrictive intervention in this situation? What can be done to reduce the need for future restrictive interventions?)*

Has the Person-centered Planning or Child & Family Team previously addressed this issue? ☐ Yes ☐ No

Does consumer have a crisis plan? ☐ Yes ☐ No **Was the current plan effective in addressing this issue?** ☐ Yes ☐ No

Does consumer have a behavior plan? ☐ Yes ☐ No **Was the current plan used prior to the intervention?** ☐ Yes ☐ No

Has the need for a crisis or behavior plan (or plan revision) been communicated to the service planning team? ☐ Yes ☐ No

Describe plans for follow-up:

Persons notified:	**Name**	**Date**	**Time**
Person-centered Planning Team Representative	_____	___/___/___	___:___☐am ☐pm
Host LME *(specify)* _____	_____	___/___/___	___:___☐am ☐pm
Legal Guardian	_____	___/___/___	___:___☐am ☐pm
Other *(specify)* _____	_____	___/___/___	___:___☐am ☐pm

Signature/Title of Staff Completing Form _____ Date ____/____/____

Supervisor's Signature / Title _____ Date ____/____/____

Program Director's Signature / Title _____ Date ____/____/____

CONFIDENTIAL **DHHS Restrictive Intervention Details Report** *CONFIDENTIAL*

***Page 4 Instructions**: This page is available for the provider agency or any agencies receiving the report to use for internal tracking and follow-up purposes. Leave this page blank when sending a report to the LME and/or other agencies..*

RESTRICTIVE INTERVENTION FOLLOW-UP *(for internal use only)*

Report Receipt Date: _____/_____/_____

Current Consumer Status:

LME's (or Other Oversight Agency's) Response:

Follow-up Notes: